The Fields Care Home

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The Fields is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Fields accommodates up to 24 people in one building and provides accommodation over four floors which are served by a lift. At the time of our inspection, 18 people were accommodated in the home. These were older people who require personal care, including people who live with a dementia or sensory impairment. The home is not registered to provide nursing care.

This inspection took place on 24 and 25 September 2018 and the first day was unannounced.

At our previous focused inspection on 16 and 24 May 2018 the home was overall rated 'Requires Improvement'. At this inspection we found that there had been improvements and the service is now rated as 'Good'.

At this inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. The manager of the service has submitted an application to be registered but that is yet to be assessed by CQC.

Where risks were identified to people who used the service or to the environment these were assessed and plans put in place to reduce them. Risks in the environment identified at the last inspection had been removed.

People received their medicines safely and were supported to access the support of health care professionals when needed. Medicines processes were being monitored and actions taken when errors occurred.

People were protected from the risk of abuse because staff understood how to identify and report it.

There were enough staff to meet people's needs and people told us they felt safe because staff were available to help them. Staff had been recruited in a safe way and checks made to ensure they were suitable to work with vulnerable people.

Staff told us they received training to be able to carry out their role. The manager monitored this and had planned the training updates required so that staff continued to have the necessary knowledge and skills. We saw that staff had received recent training to meet the needs of people living in the service.

Staff received effective supervision and we saw that their appraisals were in progress for this year. They told us they found the manager very supportive and that they were given the daily supervision they needed to do their jobs effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff were not always clear about which people were deprived of their liberty, but care files were updated to make it easier for staff to access this information.

People received a varied and nutritional diet that met their preferences and dietary needs. The service provided homemade food and drinks which were adapted for different diets.

The interactions between people and staff showed that staff knew the people well.

Care was planned and delivered in a way that responded to people's assessed needs. Care plans contained detailed information about people's personal preferences and wishes as well as their life histories. We found that the care files we checked had inconsistencies as people's needs had changed and sections had not been updated correctly. We spoke to the manager and staff and saw that practices reflected current needs and care plans were updated immediately once we highlighted these errors.

The management team were approachable and they and the staff team worked in collaboration with external agencies to provide good outcomes for people. People, relatives and staff felt any concerns would be taken seriously and acted on.

The provider and the manager had a commitment to work together to improve the service and both were present in the service and took their part in monitoring its quality and effectiveness.

Processes were in place to assess and monitor the quality of the service provided and drive improvement. This included in relation to incidents, accidents and complaints. We found that systems had improved to better identify shortfalls and address these where they occurred.

Areas of the home had been adapted to better meet the needs of people living with dementia based on good practice principles. Some further improvements to the environment were planned.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service had improved and was now safe.

The cleanliness and safety of the environment had improved and monitoring checks were in place.

People were protected against the risks associated with the unsafe use and management of medicines.

Accidents and incidents were appropriately recorded and investigated, risk assessments were in place and staff had been trained in how to protect vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff were supervised, appraised and had training to undertake their roles effectively.

People received the support they needed with eating and drinking by staff who were trained in the support of people with nutritional needs.

Staff had a good understanding of people's capacity and when best interest decisions were required, however lacked clarity about who was deprived of their liberty. The manager took immediate actions to improve the information available to staff relating to this.

Is the service caring?

Good

The service was caring.

Everyone we spoke with told us the service was caring. Relatives told us people were treated with dignity and respect.

We observed positive interactions between people and staff that promoted people's privacy, dignity and independence. We saw documentation to support these caring practices.

Is the service responsive?

Good

The service was responsive.

People, relatives and staff told us that the service was responsive to people's needs. Staff responded to people's health and wellbeing needs and there was detailed documentation in relation to people's care and support.

We found that there were very few complaints about the service but where these occurred actions were taken to respond to the complainant and to make improvements to the service.

Is the service well-led?

Good

The service had improved and we found it was now well-led.

Systems to monitor the quality of the service had been improved and were identifying and addressing issues. Action plans were being used to monitor progress in the service.

Regular meetings were held for people who lived in the home and staff, which provided opportunities to have a say about how the service was run.

People and their relatives gave positive feedback about the home and told us there was a more positive and open culture.

The Fields Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

The first day of this inspection was unannounced and took place on 24 September 2018. This meant the provider did not know we were coming. The second day was announced and took place on 25 September 2018.

The first day of the inspection was carried out by one adult social care inspector and an inspection manager. The second day of the inspection was carried out by one adult social care inspector.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send to CQC within required timescales. We contacted the local Healthwatch team and obtained information from the local authority commissioners for the service and the local authority safeguarding team. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with five people who lived at The Fields. We spoke with the provider, manager, three senior carers, three care workers, the cook and the maintenance person. We also spoke with three relatives of people who used the service, and with two visiting health care professionals.

We looked around the home and made observations of people and staff interacting. We viewed a range of records about people's care and how the home was managed. These included the care records of four people, medicine administration records of four people, recruitment records of three staff, training and supervision records and other records in relation to the management of the service.

Good

Is the service safe?

Our findings

At the previous inspection in May 2018, we found the service was not always safe, and was rated 'Requires Improvement' in this area. This was because risks to people and the environment and medicines were not always being managed safely. During this inspection we saw that risks to people's safety had been assessed and plans were in place to remove or reduce any identified risks.

People who used the service told us, "Yes I feel safe, someone comes to check on me three or four times during the night" and "Safe, yes I think so."

We observed that there were sufficient numbers of staff on duty to keep people safe during our visits and people's needs were responded to promptly. People and their relatives told us there were staff available when they needed them. There had been some changes to the staff team but no one using the service or any relatives told us this was negatively impacting on their care. For example, one person told us, "They [staff] are all around if you need them."

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people working with children and vulnerable adults. We saw that people who used the service had recently been involved in interviewing for new staff and they told us they had enjoyed being part of this process.

We saw that the provider had policies and procedures explaining how staff should respond to whistleblowing and safeguarding concerns. Staff told us they knew how to recognise abuse, what action to take to and how to report their concerns. Staff had received training in safeguarding and told us they were confident that the management would act on any concerns they raised. The service had referred to the local authority as required and completed investigations into concerns raised.

Appropriate arrangements were in place for the safe administration and storage of medicines. We saw that these processes had improved and that if errors were made there were processes in place to take actions to reduce the risk of them happening again. We checked medicine administration records and observed people being given their medicines safely and at the right times. Staff had received training in the safe handling of medicines and had regular checks to ensure they remained competent to administer medicines. Where people chose to manage their own medicines, appropriate assessments had been completed and there was a system in place for the safe storage of these. We saw that guidance was given to staff about the application of topical medicines and records were kept showing these were applied. The manager had also arranged for an audit to be completed by the pharmacy who supplied their medicines to monitor the safety of the service's medicines management.

People who used the service had risk assessments that described potential risk, the safeguards in place to reduce the risk and action taken to mitigate the risks to the health, safety and welfare of people. These covered areas such as nutrition, skin integrity, moving and handling and specific risks such as around behaviour and mental health. We found that these managed risks in the least restrictive way, were detailed and regularly reviewed. Although risk assessments had improved we still found some small inconsistencies between people's risk assessments and care plans. When we discussed this with staff we saw that care practices were current but documents were not being consistently updated when people's needs changed. We discussed this with the manager and these risk assessments were updated immediately. For example, we saw that one person's risk assessment stated that they needed to be given medicines covertly (without their knowledge). On checking with staff, medicines charts and other documentation, we saw that this person had not needed to have medicines covertly and this was only assessed for as a precaution after a previous episode of ill health. The manager updated these records during the inspection.

We observed that the premises were safe and secure and that checks were in place to identify any safety concerns. Risks to the environment had been assessed and plans were in place to reduce any identified risks. These included risks in the event of a fire. Fire alarm and fire equipment service checks were up to date, fire drills took place regularly and people had Personal Emergency Evacuation Plans (PEEPS) in place. We discussed with the manager the need to keep PEEPS records in an accessible but secure location and they told us a lockable cupboard would be built near the front door to house these securely. In the meantime, these would be kept in the manager's office. Accidents and incidents were monitored for any trends, and learning from these used to inform safe working practices.

Staff protected people from the risk of infection by following the provider's infection control procedures. We observed staff wearing personal protective equipment, such as gloves and aprons when delivering care. The relatives we spoke with all commented about the cleanliness of the home and that the home was odour free. One person told us, "My room is well cleaned."

Good

Is the service effective?

Our findings

People and their relatives told us they felt they received care from competent staff. No-one raised any concerns with us about how staff were trained or how they fulfilled their roles. One person told us, "If I want to know something I ask the carers and they tell me." One relative told us, "Staff seem very good." Another relative said, "Staff are brilliant."

All staff we spoke with told us they were provided with training that enabled them to do their job and meet people's needs. Staff had training in a range of subjects covering: moving and handling, health and safety, record keeping, food hygiene, first aid, safeguarding, mental capacity, confidentiality, medicines, privacy and dignity and equality and diversity. Staff also had training specific to the needs of people using the service such as epilepsy and Parkinson awareness. Training was regularly updated and reviewed to ensure staff had current knowledge.

Staff received regular supervisions. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. A new system for appraisals had been introduced. This was a two-part system which asked staff to complete part of the appraisal document prior to a meeting. Staff we spoke with told us they had been given their appraisal forms to complete and we saw that the meeting was scheduled. Staff told us, "I have regular supervision… I'm due an appraisal next week. I've been given something to complete."

We spoke with a new member of staff who told us they were spending their first week shadowing an experienced member of staff. They told us, "All my certificates are up to date." Another new member of staff confirmed they were in the process of completing their induction including the 'care certificate', a recognised induction standard for staff new to working in care. We saw that these staff had an enhanced level of supervision and support.

People's needs were assessed before they started using the service. A detailed pre-admission assessment was carried out that recorded people's individual needs. These assessments and ongoing assessment of people's needs were used to develop support plans.

We received positive feedback about the meals and saw that real choice was promoted with a variety of different alternatives being provided at each meal. People were offered a choice as meals were being served and referred to a menu board to know what was on offer. Pictures of the food were displayed to help people with their choices. People were given appropriate assistance from staff during their meals.

Staff had received training in nutrition and in supporting people to maintain healthy diets. People were weighed regularly and any risks identified were monitored by the manager. Staff were aware of the need to encourage good fluid intake. There were signs reminding staff of the importance of monitoring this in hot weather. Staff were aware of who needed to be encouraged to drink more and what actions to take if their fluid intake decreased. One relative told us, "[Family member] was getting water infections every fortnight, since he's been here there have been no problems. He gets lots of drinks. The increased water intake is

keeping it at bay."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that there were records of assessments, authorisations and requests in place. Where people were unable to make decisions, best interest decisions had been made on their behalf and these were recorded. We saw that care files did not clearly explain people's DoLS and any conditions in relation to these. When we spoke with staff they were not sure who was subject to DoLS. We found that the conditions of people's DoLS were being met but there was a lack of clarity about why certain restrictions were placed on people's care. We discussed this with the manager who updated the care files so that DoLS information was at the front of care files and prominent for staff to see. Staff were made aware of the changes.

The service had sought consent from people for the care and support they were provided with, and for the sharing of information and photography. Where people were unable to provide consent, this was recorded.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records were up to date and showed people and family members had been involved in the decision-making process.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, district nurses, dietitians, SALT and hospital appointments. One person told us, "Staff do everything you want, I see the chiropodist. One morning I was sick and they got the people out to check it out."

We saw that the signage in the home had been improved and more signs had been added, for example to show people which rooms were toilets. People had name plaques on their doors and there was a board in reception showing all the staff who worked in the home. A second board was planned that would, with people's permission, have photographs of everyone who used the service. We observed that good practice had been followed, such as there being contrasting handrails and coloured toilet seats, all of which are designed to make it easy for people with dementia to orientate themselves in the home.

Good

Is the service caring?

Our findings

People and relatives told us they thought the service was caring. One person said, "Yes, they [staff] ask how you are going." Another person told us, "The home was recommended to us. I liked the atmosphere. It's wonderful. I appreciate everything they do in this place." Relatives told us they were made to feel welcome in the home. One told us they were invited to stay for meals and another said, "We get offered tea and coffee. We've been taking [family member] into the garden, staff come out with tea for us."

Thank you cards were displayed in the building which gave positive feedback on the caring nature of the service. For example, one stated, "We really appreciated the way you cared for [family member] and made them feel part of the family atmosphere."

Staff told us the service was caring. One staff member said, "I love it. It's warm, friendly and we put the residents first." Another told us, "Everyone likes to help you out the best they can. It's nice for the residents that everyone gets on." A healthcare professional told us, "They [staff] get very attached with patients. It's a nice family feel, not regimental. They seem to spend a lot of time with people. Do a lot of group things."

We observed caring interactions between staff and people who used the service. For example, one staff member chose to have her lunch break in a resident's bedroom. They told us they liked to do this because the person liked to chat and have one to one time. We saw people being carefully assisted around the home and guided to their bedrooms, for example.

We observed staff speaking with people in a respectful way, using their first names and giving them time to answer questions. We also saw staff knocking and asking if they could enter people's bedrooms. People told us that staff treated them with dignity and respect. One person said, "Oh yes, they always do." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported to be as independent as possible. One person told us, "They [staff] help you if you can't manage. You can do things on your own or they can help you." We saw that people were involved in the daily routines of the home. One person was folding napkins ready for the next meal and another person assisted others to put on dignity bibs prior to the meal. These people told us these were their "jobs" which they enjoyed doing. We observed staff offering someone assistance and asking, "Do you want me to help you or would you like to do it yourself? Can you manage?"

People were supported to access advocacy services when needed. Advocates help to ensure that people's views and preferences are heard. We saw that details for the advocacy service were displayed in the entrance to the home for people and staff to access.

Good

Is the service responsive?

Our findings

Care files we reviewed were person centred and had been reviewed regularly. Person centred means the person was at the centre of any care or support plans and their individual wishes, needs and choices are considered. People's histories, backgrounds, interests, likes and dislikes were captured. As were any relevant details people wanted to share about their cultural, sexual or spiritual identify and how staff could support them and protect them from discrimination. Care plans included details about what was important to the person, such as; preference in relation to the way they liked to dress, which toiletries they liked to use and their preference around their diet. For example, one care plan said, "I like to dress smart casual."

Checks were made to ensure that people were happy with the way their care was delivered. Care plans reminded people that they could see their care records at any time, reviews were held with the person, and their relatives if they chose. People's choices were documented and we observed choice was given at the point care was delivered.

At the time of our visit the home did not have an activities co-ordinator and had not had one in post for four weeks. The manager told us that a new activities co-ordinator had been appointed and would start working shortly subject to recruitment checks being completed. Relatives we spoke with were also aware a new activities co-ordinator had been appointed. We saw that staff were providing daily activities in the interim period and we observed quizzes and bingo taking place. The manager also told us that some relatives had been helping by providing quizzes when they visited the home. One person told us, "There is very much going on, films and activities going on. I like a game of dominoes." Another person told us, "The hairdresser visits once a week. We have sing-alongs, play cards and dominoes."

We saw that people were involved in the local community where they chose to do this. A local church group and a community choir visited the home. On occasion people visited the community centre or went to watch local cricket matches. People could access the local bus but mainly preferred to walk around the gardens. The manager told us that they hoped that the new activities co-ordinator would improve the links with the local community and ways to do this had been discussed including more involvement from local school children and arts students. The provider and the maintenance person told us they planned to develop the gardens to include raised planters and ornaments to make the garden a more interactive and useable space.

The service had received very few complaints. Where these had been received they had been responded to within the timescales set out in the complaints policy. Guidance on how to make a complaint was clearly displayed for anyone visiting the home. People and relatives we spoke with told us they had no current concerns but they would feel confident in making a complaint if needed. For example, relatives told us, "We've no complaints. If there is a problem they jump on it straight away."

When we visited the home one person had very recently passed away and another person was receiving end of life care. We saw that plans were in place reflecting discussions with the person, their relatives and other relevant parties about how care should be delivered and what the person's wishes were. Staff had also

received training on how to care for someone at the end of their life. We spoke with a relative who told us, "[Family member] felt really cared for. They sat in the lounge smiling. They were encouraged to join in…they wanted that independence." They went on to say that the family had also felt supported by the service. A healthcare professional who had been involved with the family member's care said that family had been able to stay in the home overnight with their relative when their health deteriorated.

Good

Is the service well-led?

Our findings

At our previous inspection in May 2018 we found the service was not always well-led and was rated 'Requires Improvement' in this area. This was because the service did not have a registered manager in post and quality assurance systems were not identify and addressing errors or driving improvement. We asked the provider to submit a monthly action plan so that we could monitor service improvements. From these we could see the provider had taken actions to address all the areas of concern previously raised. During this inspection we found that the service had improved to 'Good'.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed in January 2018 and had submitted an application to become the registered manager, however this application had not yet been assessed by CQC. The manager explained that there had been a delay while they gathered the relevant documents they needed for this application.

We found that there was a clear commitment to make on-going improvements in the home. We had previously seen that planned developments in the home were not documented and that audit systems were incomplete and not effective at identifying all the issues occurring in the home. At this inspection we saw that these systems had been improved and that documentation was in place to monitor, analyse and improve practices. We saw that audits that had not previously been in place, for example for medicines, were now being completed and were identifying and addressing issues. We did, however, still identify some minor inaccuracies in care records which had not been picked up in the relevant audits. We discussed this with the manager who agreed that staff required further coaching and training to ensure that care files were updated and reviewed consistently. This training was on-going and the manager was continuing to make checks after files had been reviewed.
We received positive feedback about the service and the management. People who used the service knew the management and told us they saw them regularly in the service. Relatives told us they thought communication was good. One relative said, "We see the manager and the deputy, they always tell us what's going on." Several people, relatives and staff mentioned the recent staff changes to us but also said that they thought the current staff team was very good. Staff told us, "I have always found it homely and the people pleasant." Another said, "We've got a lovely staff team now. Everyone is wanting to improve. I think it is really getting there and staff are doing things how they should be done. It's much better and the home has a lovely feel." A third told us, "You feel like you're home yourself, not just the residents. The manager comes and helps. If you need anything from [manager] they're always there, you can speak to them about anything at all."

Audits systems included regular checks made by the provider, manager and senior staff. These were daily and weekly checks of the service and a monthly visit from the provider. Audits covered all areas of the service such as, health and safety, infection control, medicines management, complaints and nutrition. The provider visits were detailed, including observations of staff and discussions with people and their relatives.

The provider also told us they were regularly present in the service on an informal basis speaking with people or supporting staff. Actions from audits were signed off by the manager and fed into the home's overarching development plan.

Practices issues were discussed with staff through regular supervisions and staff meetings. These included the importance of clear and accurate record keeping and the consequences of errors and omissions.

The manager worked flexible hours and was regularly present in the home early in the morning to support night staff and worked until late on an evening on certain days to be available for relatives who visited in the evenings. A member of night staff we spoke with told us, "[Manager] comes in early to see us and give night staff support. We chat, it takes the pressure off. It's brilliant." They also told us, "There's been lots of change, it's definitely improved. Better management, better support and more communication." The manager told us that night staff were asked to do the occasional daytime shift to try to improve communication and relationships between the shifts. Staff we spoke with thought this had been effective.

We saw evidence that best practice was promoted and that the service had a learning culture. The service had 'champions' roles, for areas such as: dignity, infection control and nutrition. These were where staff had taken the lead in these areas and supported other staff to improve their practices. A 'learning from good practice' file was also shared with staff that contained guidance documents such as those from NICE (National Institute for Health and Care Excellence, who provide evidence based guidance on health and care) and the Department of Health. The manager attended a 'strategy forum' hosted by the local authority and attended by other care providers. From these meetings they had become part of a pilot scheme reviewing regional policy on homely medicine (a homely medicine is another name for a non-prescription medicine available over the counter in community pharmacies, used in a care home for the short term management of minor, self-limiting conditions).

As at the last inspection some relatives and staff told us they felt the home was making improvements. One staff member said, "We put ideas forward to [manager], we're involved in care plans more, get our say in meetings", and "I feel more involved now."

We found minutes of regular meetings held with people and relatives. These were used to measure quality and gain feedback on the services offered, such as activities. These were recorded and made available for those who could not attend. A comments book was available in the entrance to the home; several people had written comments including, "My [family member] gets fab care. All the staff understand his needs and wellbeing. He is looked after to a high standard. We as a family have peace of mind." Another comment was, "Staff are very caring and see to all [family member's] needs." Quality assurance questionnaires results were displayed in the service; only two negative comments were received about staffing and laundry and these had been responded to.

The provider worked with the wider community in supporting people's health and wellbeing. We saw interaction between the home and local schools, churches and community groups.

Professionals we spoke with told us the home consulted with them and responded to their requests. One healthcare professional told us, "If staff have any concerns about anything they ring us." The service worked in partnership with many agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support. We saw that the home had sought advice and guidance from other agencies involved in people's care. None of the agencies we contacted prior to the inspection raised any concerns.